DRAFT TEXT- FOR DISCUSSION ONLY

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

TITLE 28, CALIFORNIA CODE OF REGULATIONS
DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE
CHAPTER 2. HEALTH CARE SERVICE PLANS
ARTICLE 7. STANDARDS

PROPOSED ADOPTION OF SECTIONS 1300.89.1 AND 1300.89.3
Control No. 2006-0663

PROPOSED TEXT

Section 1300.89.3: Medical Underwriting; Prohibition of Post Claims Underwriting

(a) Definitions

For purposes of section 1389.3 of the Act:

(1) The term "medical underwriting" means the process, to be completed by a plan before issuing a subscriber contract, by which the plan:

(A) Reviews and evaluates the health status and health history of an applicant, including but not limited to the health information provided by the applicant and other sources of health information available to the plan, including but not limited to the applicant's medical records, the applicant's claims history with the plan, and commercially available claims databases;

(B) Assesses, through the application of rating criteria and guidelines based on sound actuarial principles and underwriting practices, the prospective financial risk to the plan of providing future health care coverage to the applicant; and

(C) Determines whether or not to accept the identified financial risk of providing health care coverage to the applicant.

(2) The phrase "resolve all reasonable questions arising from written information submitted on or with an application" means the process, to be completed by a plan before issuing a subscriber contract, by which the plan:

(A) Reviews the responses in, or submitted with, a coverage application to identify, at a minimum, responses that appear inconsistent, ambiguous or incomplete, or indicate that the applicant may have misunderstood the question; and

(B) Obtains and reviews additional information necessary to resolve such questions reasonably apparent in the application and reasonably related to the plan's medical underwriting process. The additional information necessary to resolve all reasonable questions may include, but is not limited to, information obtained through the plan's further

communications with the applicant, or review of medical records and other sources of health information for the persons to be covered under the subscriber contract. Communications between a plan and an applicant, upon which the plan relies to complete medical underwriting, shall be documented in writing and presented to the enrollee for review and signature.

(3) The phrase "limiting of a plan contract" means a modification of terms, conditions, or assumptions affecting the subscriber contract after it has been issued, including, but not limited to:

(A) A decrease in benefits under the subscriber contract;

(B) An increase in the limitations, restrictions, exceptions, or exclusions from coverage;

(C) An increase in premium rates, co-payments, coinsurances, or deductibles; or

(D) An increase in a subscriber's or enrollee's risk rating, financial risk calculations, or calculations of a similar nature or import.

(b) No subscriber contract shall be cancelled or rescinded because of a misstatement or omission in the coverage application, unless the misstatement or omission is a result of the applicant's willful misrepresentation and the omitted information would have been a basis for denial of coverage pursuant to the plan's underwriting criteria, guidelines, policies, and procedures.

(c) Misrepresentation by one subscriber or enrollee under a subscriber contract shall not be a basis for cancellation, rescission, or limitation of coverage for all enrollees under the contract. No plan shall rescind, cancel, or limit a subscriber contract on the basis of an alleged misstatement or omission in the coverage application after the contract has been in effect for a period of two years.

(d) A plan's medical underwriting guidelines, rating criteria, policies, and processes shall be:

(1) Developed with involvement from actively practicing actuaries and medical underwriters that have appropriate experience and expertise regarding health care service plans;

(2) Consistent with sound actuarial principles and sound medical underwriting practices; and

(3) Evaluated at least annually, and updated if necessary.

(e) All plans that engage in medical underwriting shall have written policies and procedures that specify the plan's standards and processes for:

(1) Reviewing coverage applications before issuing a subscriber contract, including completing medical underwriting and resolving all reasonable questions arising from written information submitted on or with a coverage application;

(2) Ensuring fair fact gathering, review, determination, and appeals, including consistent and accurate application of underwriting guidelines, criteria, policies and procedures, before rescinding, canceling, or limiting a subscriber contract based on an alleged misstatement or omission in the coverage application;

(3) Ensuring fair and reasonable enrollee notice and opportunity to participate in the plan's investigation, including mailing notice of the plan's investigation not less than 15 days before the effective date of rescission, cancellation, or limitation of the subscriber contract. In addition to the applicable content required by section 1300.65 of title 28, this notice regarding the plan's investigation shall fully and fairly disclose: the information under investigation; the actions the plan may take at the conclusion of its investigation; the enrollee's financial responsibility to reimburse the plan for amounts paid by the plan to providers, if the plan rescinds, cancels or limits coverage; and an explanation of how the subscriber may participate in the investigation, including how to contact the plan employee handling the investigation. The notice shall also include:

(A) A copy of the application form as submitted by the subscriber; and

(B) The following statement, with the first sentence in 14-point bold font and the remainder of the paragraph in 12-point font:

"You have the right to request a review by the Department of Managed Health Care if [Plan] cancels or rescinds your coverage. You may request a review by the DMHC on line at www.hmohelp.ca.gov, or by calling the DMHC at 888-466-2219. You also have the right to participate in [Plan's] investigation (call [Plan] at [phone number]) and the right to an expedited appeal through [Plan's] grievance process (call [Plan] at [phone number])."

(4) Quality assurance monitoring and appropriate corrective action for non-compliance.

(f) During the time in which a plan is investigating an alleged misstatement or omission in a coverage application, it shall not delay, deny, or modify medically necessary covered services that are needed on an urgent or emergent basis. A plan that delays, denies, or modifies non-urgent medically necessary services based on its investigation into an alleged misstatement or omission in the coverage application shall:

(1) Disclose the investigation as the reason for delay, denial, or modification of the services in all applicable communications with providers or enrollees; and

(2) Within 30 days of commencing its investigation, complete its investigation and deliver the plan's determination to the subscriber.

(g) A plan's internal processes for (1) conducting investigations, (2) rendering initial determinations, and (3) determining enrollee appeals, regarding an alleged misstatement or omission in the coverage application shall be separate and independent of each other. Enrollee complaints and grievances regarding rescission, cancellation, or limitation of a plan contract shall be handled on an expedited basis.

(h) A plan's determination to rescind, cancel, or limit a subscriber contract based on an alleged misstatement or omission in the coverage application shall be subject to the Director's review pursuant to section 1365(b) of the Act.

(i) This section does not modify any existing statutory requirements or restrictions regarding termination of guaranteed issue coverage pursuant to section 1366.35 of the Act and article 11.5, commencing with section 1399.801 of the Act.

(j) All evidences of coverage and disclosure forms issued or amended on or after January 2008 shall contain a description of the plan's processes for appealing the plan's rescission, cancellation, or limitation of the subscriber contract based on an alleged misstatement or omission in the coverage application, and a statement disclosing the right to a hearing by the Director pursuant to section 1365(b) of the Act.

(k) Filing, Implementation, and Reporting Requirements

Commencing on January 1, 2008, and continuing through December 31, 2009, every full service plan shall file with the Department, on a semi-annual basis, due on the last day of the month immediately following the reporting period, a report documenting the following information for each subscriber contract the plan rescinded, cancelled, or limited during the reporting period on the basis of an alleged misstatement or omission in the coverage application:

(1) The name of the contract holder, the application form identification number, and the specific basis for the plan's action;

(2) The dates on which coverage commenced; coverage ended or was limited; the advance notice of investigation was mailed; and the notice confirming termination or limitation of coverage was mailed; and

(3) Whether the subscriber appealed the plan's action through the plan's grievance process, and if so, the plan's resolution of the appeal, including specifically whether the plan reinstated coverage.

Note: Authority cited: Sections 1344, 1346, 1359, and 1389.3, Health and Safety Code. Reference: Sections 1342, 1351, 1352, 1359, 1360, 1363, 1365, 1365.5, 1367, 367.01, 1367.6, 1367.8, 1368, 1370, 1373, 1374.7, 1374.75, 1389.1, 1389.2, 1389.25, 1389.3, 1389.4 and 1389.5, Health and Safety Code.

Section 1300.89.1: Applications for Health Care Coverage

(a) All questions, statements, and disclosures in a coverage application form shall be clear, specific, and unambiguous. A question relating to an applicant's health shall be based upon medical information that is reasonable and necessary for medical underwriting purposes.

(1) A question, statement, or disclosure shall be deemed unclear and not specific if:

(A) It is a compound question or contains double negatives;

(B) It contains words, terms, or phrases that may be misunderstood by a person not possessing special knowledge of health care or health care coverage;

(C) It requires the applicant to evaluate the significance or cause of symptoms, or to guess or speculate regarding the kinds of symptoms that may be significant or of interest to the plan; or

(D) It is intended to elicit health information regarding more than one person. A separate health questionnaire shall be provided for each person applying for coverage.

(2) A question, statement, or disclosure shall be deemed ambiguous if it may be understood in two or more possible senses or ways.

(3) A question relating to an applicant's health shall be deemed unreasonable and unnecessary if it is not designed to elicit medical information that is necessary to the plan's calculation of prospective financial risk for the coverage being offered, or is otherwise not consistent with sound actuarial principles and sound underwriting practices.

(b) Each question on a coverage application shall clearly state the period of time to which the question is directed. All such periods of time shall be reasonable and based upon sound actuarial standards for medical underwriting, but in no event shall the period of time exceed ten years.

(c) All coverage applications shall include a disclosure immediately after the applicant's signature line that requires each broker or agent who receives a coverage application on behalf of the plan to provide his or her name, contact information, California license number, and an affirmation regarding whether or not the broker or agent assisted the applicant in completing any part of the application.

(d) Coverage applications received by a plan electronically and/or via a solicitor shall be submitted in writing to the applicant for review and signature.

Note: Authority cited: Sections 1344, 1346, 1364, and 1389.1, Health and Safety Code. Reference: Sections 1342, 1351, 1352, 1352.1, 1359, 1360, 1361, 1362, 1363, 1363.5, 1364, 1365, 1367, 1367.6, 1368, 1370, 1373, 1374.7, 1374.75, 1389.1, 1389.2, 1389.25, 1389.3, 1389.4, and 1389.5, Health and Safety Code.